The Use of Palliative and Hospice Care in the Nursing Home Setting

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CASE STUDY

Mrs. H. is a 94 year old woman with a past medical history of dementia, dysphagia and congestive heart failure. She is a nursing home resident who has lived in the facility for the past 6 years. Over the course of the last six months, the nursing home staff has noted that her oral intake has decreased; she often pockets her food and refuses her medications. She has lost 10 pounds in the past three months. The nursing staff has also noticed that her functional status has deteriorated significantly—she is now dependent for all activities of daily living (ADL). Despite being evaluated by speech therapy and being placed on the appropriate diet, she was recently hospitalized for aspiration pneumonia. Though aggressive measures have been taken to prevent skin breakdown, she has a Stage III pressure ulcer on her coccyx. Her speech has become garbled and unintelligible. When the nursing home staff attempts to provide care, Mrs. H. moans and resists. Her daughter, who is her Durable Power of Attorney for Health Care, says, “My mother would not want to suffer; she would want to be comfortable. What can I do to respect her wishes?”

The function of the nursing home as a long-term care facility continues to evolve. The nursing home remains a place where some older persons come to reside; however, it is increasingly common for patients to come for rehabilitation from injury or acute illness. Still others come for wound care and specialized treatments that include long-term intravenous antibiotic therapy. As the function of the nursing home has become diverse, an important factor has come to light—a growing number of older persons are spending their last days in nursing homes. In fact, nationally, more than 20% of deaths occurred in nursing homes, and in Rhode Island, the percentage of patients who died in nursing homes increased from 20% in 1989 to 35% in 2001.12 Given that the nursing home is increasingly becoming the site of death for our nation’s elderly, the utilization of palliative care in the nursing home setting should be addressed.

Several studies suggest that nursing homes residents who are nearing the end of life have unmet needs with regard to pain, dyspnea, depressed mood, and anxiety;5,6 and other studies have noted unmet needs of dying patients for emotional and spiritual support.6,5 Bereaved family members have continually expressed concern about not being informed of their loved one’s condition, about nursing home staffing levels, and about the provision of spiritual support; family members have also reported pain control for residents as a top priority.6,7 Hospice and palliative care services have been found to improve the quality of care that patients and their families receive at the end of life. Terminally ill cancer patients on hospice have expressed more satisfaction with their care than patients who did not use hospice services; and hospice patients’ familial caregivers have shown somewhat more satisfaction and less anxiety than did caregivers of non-hospice patients.4 Family members of patients receiving hospice services have been found to be more satisfied with the overall quality of care their loved ones received. This improvement in quality extends to nursing home residents as well. Miller et al. found that nursing home residents receiving hospice care in the last 48 hours of life were more likely to have their symptoms adequately addressed.9 Additionally, studies have shown that residents on hospice are more likely to receive opioids for their moderate to severe pain than non-hospice residents. Hospice residents are twice as likely to receive regular treatment for daily pain than non-hospice residents.10,11 Family members have been found to believe that nursing home hospice services improve quality of care for symptoms, reduce hospitalizations, and add value and services for dying nursing home residents.12

There are several barriers to hospice utilization in the long-term care setting. Low reimbursement13,14 and nursing home administrators’ attitudes toward hospice may influence its availability in nursing homes.15 Lack of knowledge among physicians, staff, and families; staff shortages and turnover; and difficulties in determining prognosis have also been cited as obstacles.16 For these reasons, educational interventions are being developed to increase physician and staff awareness of hospice as an option for end of life care;17 furthermore, disease-guidelines aid physicians in determining whether residents are appropriate for hospice services.18,19

Now let’s turn our attention back to Mrs. H., our 94 year old nursing home resident with severe dementia. Mrs. H. has multiple factors that make her eligible for hospice services: the progression of her dementia, significant decline in function, and recent hospitalization for pneumonia.20 Upon further discussion with her daughter, hospice was presented as an option. Mrs. H was subsequently enrolled in hospice services, and the nursing home and hospice staff provided the patient and her family with care that was consistent with her wishes. Mrs. H. subsequently died a “good death,” and bereavement and spiritual support were provided to her family well after the death. Mrs. H. is just one example of how hospice services can improve the quality of the dying experience for patients and their families. Continued education, collaboration, and eradication of barriers will continue to improve the care nursing home residents and their families receive at the end of life.
**RESOURCES:**
1. The National Hospice and Palliative Care Organization: [http://www.nhpco.org](http://www.nhpco.org)
4. The End of Life/Palliative Care Education Resource Center: [http://www.eperc.mcw.edu/](http://www.eperc.mcw.edu/)

**REFERENCES**

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